Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Basil Gant a prisoner at HMP Norwich on 21 May 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Basil Gant died from cancer of the windpipe, in Norwich and Norfolk University Hospital, on 21 May 2016, while a prisoner at HMP Norwich. He was 65 years old. I offer my condolences to Mr Gant's family and friends.

I am satisfied that, generally, Mr Gant received a reasonable standard of care at the prison, equivalent to that he could have expected to receive in the community. Healthcare staff at Norwich managed his care in line with national clinical guidelines. It was unfortunate that Mr Gant missed a very important appointment because nurses appear not to have advised him to fast the night before.

It is disappointing that Mr Gant was double cuffed during the journey for his last admission to hospital and that he was still restrained by an escort chain during an uncomfortable invasive procedure and within an hour of his death. This is not acceptable for an individual in Mr Gant's condition; we would expect a more considered approach from a prison which is used to dealing with elderly and very unwell prisoners and it is concerning that we have previously made critical findings in this area.

This version of my report, published on my website, has been amended to remove the names of the staff and prisoners involved in my investigation.

Richard Pickering
Deputy Prisons and Probation Ombudsman **January 2017**

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Summary

Events

1. Mr Basil Gant was remanded to HMP Norwich on 8 February 2016 for sexual offences and was noted to have had issues with substance abuse, his kidney and liver function, and hepatitis. Healthcare staff took appropriate steps to address any potential drug withdrawal and to assess his liver and kidney functions.

2. On 4 April, Mr Gant reported that he was finding it painful to swallow and that he also had pains in his stomach or his chest. A prison GP prescribed a gastric medication as historic electrocardiograms (ECG – which measure heart rhythms) had not revealed any cardiac issues. Mr Gant saw another prison GP on 14 April and this time reported hoarseness as well as difficulties swallowing. The doctor referred him urgently to a specialist, for an endoscopy and a gastroscopy, in line with the guidelines for suspected cancer and it was booked for 29 April.

3. Mr Gant missed the urgent appointment because he did not fast and there was no record that healthcare staff had told him not to eat. It was rebooked for 13 May. At that appointment, investigations revealed that he had a tumour on his oesophagus but it was not known how advanced it was. The hospital planned to arrange a further scan.

4. After Mr Gant returned to prison, healthcare staff implemented appropriate care plans and moved him to a more suitable wing for closer monitoring.

5. Mr Gant's condition rapidly deteriorated. He was admitted to hospital on 19 May, escorted by two officers and restrained with double cuffs. He continued to deteriorate and died on 21 May.

Findings

6. We are concerned that Mr Gant missed an urgent two week referral appointment because nursing staff appear not to have advised him to fast. With the exception of this oversight, his care was good and he received appropriate nursing, pain relief and nutritional care.

7. It is very disappointing that Mr Gant was restrained until less than an hour before he died and that officers removed the restraints only when hospital staff needed to try and resuscitate him. Given his condition, we do not consider that this was in any way appropriate.

Recommendations

- The Head of Healthcare should ensure that staff inform prisoners if they are required to fast before appointments and record in the medical record when they have done so.
- The Governor should ensure that managers understand the legal position and follow Prison Service guidance when authorising restraints for prisoners taken to hospital and that risk assessments are based on the actual risk the prisoner presents at the time.

- The Head of Healthcare should ensure that staff fully and accurately record information about a prisoner's condition so prison staff can make informed decisions about the appropriate level of restraints.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

9. The investigator obtained copies of relevant extracts from Mr Gant's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Gant's clinical care at the prison.

11. We informed HM Coroner for Norwich of the investigation, who gave us the cause of death. We have given the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Gant's brother, to explain the investigation and to ask if he had any matters they wanted the investigation to consider. He wanted information about the clinical care Mr Gant had received, including his medication and an explanation as to why officers had restrained him when he was so ill.

13. The investigation has assessed the main issues involved in Mr Gant's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

14. Mr Gant's family received a copy of the initial report. They did not raise any further issues or comment on the factual accuracy of the report.

15. The initial report was shared with the prison service. They pointed out a factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Norwich

16. HMP Norwich is a multi-function prison, which predominantly serves the courts of Norfolk and Suffolk. The prison holds up to 769 men. Virgin Care provides healthcare services. There is a healthcare centre, which provides 24-hour nursing cover and a dedicated unit for older prisoners.

HM Inspectorate of Prisons

17. The most recent inspection of Norwich was in August 2013. Inspectors reported that the prison had progressed since the last inspection. Relations between staff and prisoners were mostly positive and the inpatient and older prisoner units provided good care. However, although the nurse practitioner service was very good, there was a concern about the high use of locum GPs, which could lead to inconsistencies in treatment, care and prescribing.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2016, the IMB reported that there was strong and effective management by the healthcare centre manager and arrangements were in hand to recruit more GPs and non-agency nurses. Care provided on L Wing was done so with care and sensitivity and palliative care was considered to be of a high standard.

Previous deaths at HMP Norwich

19. As Norwich has a special unit for older prisoners, there are a relatively high number of deaths from natural causes at the prison. Mr Gant was the ninth prisoner to die from natural causes at the prison since May 2015. (There has since been another death.) We have made recommendations about restraints before.

Findings

The diagnosis of Mr Gant's terminal illness and informing him of his condition

20. Mr Gant was remanded in custody for alleged sexual and violent offences and had been at HMP Norwich since 8 February 2016 (although he had only been released from there in November 2015). Mr Gant had a history of drug and alcohol abuse, poor kidney function and liver disease (cirrhosis), hepatitis and respiratory issues.

21. When Mr Gant arrived at the prison, a nurse noted he appeared fit and well. The nurse examined and monitored him for signs of drug withdrawal and hepatitis C. She noted his heavy alcohol use in the community and monitored him for withdrawal. She set up a care plan to monitor, manage and maintain Mr Gant's safety.

22. On 4 April, Mr Gant told a nurse that he had trouble swallowing as it was painful and he also had stomach and chest pain. She arranged for a doctor to review him later that day. The doctor saw Mr Gant and noted that electrocardiograms (ECG – which measure heart rhythms) and other investigations had ruled out previous cardiac concerns so he thought it more likely that the issue was gastric. He prescribed lansoprazole to help ease the symptoms and planned to review Mr Gant in two weeks.

23. On 14 April, another doctor saw Mr Gant who reported he was hoarse and having trouble swallowing. He had not been vomiting, lost any weight or experienced any other symptoms. However, the doctor urgently referred him for an endoscopy and a gastroscopy (procedures where cameras are attached to a long tube and passed down the throat to examine the digestive system) under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

24. The appointment was made for 29 April, but Mr Gant ate beforehand so it had to be cancelled. There was no evidence in the medical record that healthcare staff told Mr Gant not to eat. The appointment was rebooked for 13 May.

25. Mr Gant continued to experience hoarseness and was clearly unwell. The appointment on 13 May went ahead and the examinations revealed that he had a tumour on his oesophagus but the stage was not known.

26. On the same day, a nurse discussed Mr Gant's diagnosis with him and on 16 May the Head of Healthcare also spoke to Mr Gant about the findings and explained biopsies to him.

27. We are concerned that Mr Gant's initial appointment on 29 April was cancelled because he was apparently unaware that he needed to fast. An entry in Mr Gant's medical record by an administrator, said that Mr Gant missed his appointment because he had eaten. When we asked the prison about it, a prison manager told us that nurses would usually personally inform the patient they needed to fast before an appointment and also tell the wing staff. However, if the prisoner had food in their room, no one would remove it as the prisoner had a choice about the matter. She was unable to comment on what had happened in

this particular case because of the lack of a record. We make the following recommendation:

The Head of Healthcare should ensure that staff inform prisoners if they are required to fast before appointments and record in the medical record when they have done so.

Mr Gant's clinical care

28. On 17 May, a doctor reviewed Mr Gant and prescribed a liquidised food supplement. He noted Mr Gant required a scan to determine the stage of the tumour. The hospital was arranging this.

29. On 18 May, a nurse noted that Mr Gant was a little unsteady on his feet. A nurse completed a full nursing assessment and arranged for appropriate care plans to be drawn up by another nurse. These covered falls, pressure sores, medication and daily living activities.

30. On 19 May, the Head of Healthcare reviewed Mr Gant. He had declined significantly and complained of pain all over his body. She consulted a prison doctor, who advised that Mr Gant be admitted to hospital. Mr Gant was transferred to hospital at 11.20am that morning. On 19 May, he had an ECG and, on 20 May, an X-Ray, although we do not know the results. Mr Gant spent much of the rest of his time in hospital sleeping and doctors planned a CT scan. (A CT scan takes images of the body's internal structures.)

31. On 21 May, hospital staff took Mr Gant to theatre for a procedure to put a camera down his throat. They gave him an anaesthetic because he found the procedure uncomfortable and fought it. At about 11.43am, after returning to the ward, he coughed up blood and phlegm. At 12.46pm, Mr Gant deteriorated and hospital staff tried to resuscitate him. They were unsuccessful and he died at 1.25pm.

32. We agree with the clinical reviewer's conclusion that Mr Gant's care at Norwich was equivalent to that he could have expected in the community.

Mr Gant's location

33. On 16 May, shortly after Mr Gant received his diagnosis of a tumour on his oesophagus, The Head of Healthcare arranged for him to be moved to a wing where healthcare staff could monitor him more closely (L wing).

34. When Mr Gant's condition declined, on 19 May, staff quickly arranged for him to be transferred to hospital and he remained there until he died.

35. We and the clinical reviewer are content that Mr Gant's location was appropriate.

Restraints, security and escorts

36. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it

clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

37. On 18 May, a nurse described Mr Gant as confused and unsteady on his feet. By the time he went into hospital on 19 May, his condition had deteriorated significantly and the Head of Healthcare said he had pain all over his body. He went to hospital as a blue light emergency.

38. The medical portion of the risk assessment, completed by the Head of Healthcare, did not object to the use of restraints and said his mobility was not impaired but that his condition restricted his ability to escape. She said that officers would have to remove restraints in an emergency situation. The security risk assessment said that Mr Gant was to be treated as an unsentenced category B prisoner. It was unsigned, but assessed Mr Gant's risks to the public, of hostage taking, escape and outside assistance as 'unknown'; that he had no history of previous absconds or violence while in custody; and that officers should remove restraints only if his life was in danger, rather than for other medical treatment.

39. A prison manager authorised two officers to escort Mr Gant and restrain him with double cuffs and an escort chain. Double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs. An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer. The prison manager confirmed that officers could only remove restraints if his life was in danger and removal for any other treatment needed the duty governor's permission.

40. During his admission to hospital, officers noted in the bedwatch notes that Mr Gant sometimes needed oxygen, was attached to a catheter, drip and a feeding tube. He was coughing up blood and had limited mobility. On 20 May, at 4.36pm, a Custodial Manager did a management check and recorded that there were 'no issues'.

41. On the morning of 21 May, Mr Gant had to have a camera inserted down his throat and this was clearly very uncomfortable for him. Despite this, officers kept the escort chain on him throughout the procedure. At 12.46pm, not long after he returned to the ward, he deteriorated to the extent that hospital staff tried to resuscitate him. At this point, another Custodial Manager removed the escort chain. She did not replace it and Mr Gant died at 1.25pm.

42. We contacted the Head of Healthcare to ask why she had not objected to the use of restraints or given more information about Mr Gant's condition on the risk assessment form, since she had previously described him as having declined significantly and in pain all over his body. Unfortunately, she was away from the prison for an extended period and not available for comment.

43. We asked the prison manager who had authorised them, why he had authorised double cuffs for the journey to hospital when these are only usually used for

healthy, category A and B prisoners and Mr Gant was clearly not healthy. He told us that he had been guided by the prisoner's category and the risk assessment information, but in retrospect he feels double cuffs were not necessary.

44. We also asked the Custodial Manager who did the management check, how he had conducted his management check on 20 May, including whether he had spoken to any hospital staff for an update. He told us that he had visited Mr Gant in person, but had not spoken to any hospital staff about his condition because of medical confidentiality. He said that his role was to check that staff were in position, handcuffs were applied correctly, paperwork was up to date and that Mr Gant was complying with staff's instructions. He commented that a prison manager had made the decision on restraints the day before, and that it had perhaps been influenced by Mr Gant's alleged offences.

45. We are not satisfied that the medical risk assessment gave enough information about Mr Gant's condition or that the authorising manager properly considered or recorded his reasons for using double cuffs. It was particularly surprising that there was so little scope for escort staff to remove restraints for treatment. We are also not satisfied that the management check considered Mr Gant's condition at the time, as it focussed on whether staff were upholding the original decision rather than whether it was still appropriate. Likewise, the escorting officers did not speak to any managers about the suitability of restraints even when Mr Gant had to undergo a very uncomfortable invasive procedure. We make the following recommendations:

The Governor should ensure that managers understand the legal position and follow Prison Service guidance when authorising restraints for prisoners taken to hospital and that risk assessments are based on the actual risk the prisoner presents at the time.

The Head of Healthcare should ensure that staff fully and accurately record information about a prisoner's condition so prison staff can make informed decisions about the appropriate level of restraints.

Liaison with Mr Gant's family

46. On 19 May, the day Mr Gant went to hospital, the prison appointed an officer as their family liaison officer. He contacted Mr Gant's brother and told him about Mr Gant's admission to hospital. Mr Gant's brother visited the hospital and the family liaison officer updated him in between visits. Mr Gant's brother was on his way to visit on 21 May, when Mr Gant's condition declined and he arrived after Mr Gant had died. The family liaison officer met Mr Gant's brother at the hospital. He offered his condolences and gave him relevant information. He stayed in touch to offer support and help with practical matters.

47. Mr Gant's funeral was on 10 June and the prison contributed to the costs, in line with national policy.

Compassionate release

48. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are

suffering from a terminal illness and have a life expectancy of less than three months. Mr Gant died before the stage of his tumour could be confirmed, which would have informed a prognosis. As he was neither convicted, nor sentenced he could not have been considered for compassionate release.

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